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ABSTRACT

A prereferral intervention program was instituted: to ensure that children within a Head Start program who had special needs were identified and referred in a timely manner; to prevent the mistaken referral or labeling of children with mild delays who did not require intervention; and to increase the effectiveness of the existing referral system. Behavioral checklists were developed and provided to teachers to aid them in identifying children with special needs. Teachers could then request prereferral consultations during which a special education consultant conducted teacher consultations, screenings, child observations, and reviewed the child's records. If, based on her findings, prereferral intervention was indicated, the consultant devised an individualized educational plan for the teacher to use with the child in the regular classroom. Follow-up consultations by telephone and in-person were conducted with the teachers and education supervisors. Results indicate that prereferral intervention can benefit teachers by giving them the confidence and tools to handle children they may otherwise have perceived as too difficult to teach. Many of the children, including some considered severely impaired, showed growth in academic and social areas when on prereferral intervention plans which is consistent with the movement to mainstream whenever possible. (Author/VW)

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THE IMPROVEMENT OF SPECIAL EDUCATION SERVICES IN AN EARLY CHILDHOOD PROGRAM THROUGH A PREREFERRAL INTERVENTION SYSTEM

BY

BETHANIE GORNY

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THE IMPROVEMENT OF SPECIAL EDUCATION SERVICES IN AN EARLY CHILDHOOD PROGRAM THROUGH A PREREFERRAL INTERVENTION SYSTEM

by

Bethanie Gorny

Cluster 21

A Practicum I Report presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1987

PRACTICUM APPROVAL SHEET

This practicum took place as described

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This practicum report was submitted by Bethanie Gorny under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

August 17, 1987

Date of Final Approval of Report

Polly Peterson, Ph.D.

Polly Peterson, Ph.D., Adviser

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ABSTRACT

The Improvement of Special Education Services in an Early Childhood Program Through a Prereferral Intervention System. Gorny, Bethanie, 1987: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood.
Descriptors: Education for All Handicapped Children Act/ Handicap Identification/High Risk Persons/Individual Needs/Mainstreaming/Preschool Children/Preschool Education/Referral/Disabilities/Screening/Special Education

This practicum was designed to address the problem of assuring that children with special needs receive appropriate special education services. The writer's experience and a review of the literature indicated that these services frequently are not delivered to children in a timely and effective manner. In addition, children with special needs which do not fit the diagnostic criteria of The Education for All Handicapped Children Act frequently do not receive any individualized assistance in the classroom. The writer's goals were: (1) to provide the teacher with an individualized educational plan for every child with a special need; (2) to improve the procedure for early identification of children with special needs; (3) to prevent unnecessary classification (labeling) of children with special needs.

The writer's solution was to institute a prereferral intervention program into the existing special education referral system. First, behavioral checklists were developed and provided to the teachers to aid them in making referrals; then, the writer responded to all referrals by conducting teacher consultations, child observations, screenings, and providing a report of findings. Next, a decision was made, with teacher and parent involvement, whether to try a prereferral intervention plan, refer for a full Child Study Team evaluation, or provide no action except teacher consultation. The writer tnen developed individualized prereferral intervention plans, conducted monitoring of the plans, and developed and administered an evaluation component.

The results of the practicum were positive. Analysis of the data revealed greater accuracy in referrals made, no classifications of children as handicapped during the implementation period, and an increase in the number of children served by the special education services division over previous years. Teachers and administrators indicated increased satisfaction with the expanded services from special education.

CHAPTER I

INTRODUCTION

Description of Community

The setting for the practicum was one of the many Head Start Programs established in every state in the country by the federal government which implemented the program twenty years ago as part of its war on poverty. Head Start is a federally funded preschool program serving children who fall within federally established income guidelines.

Eligibility for enrollment in Project Head Start mandates children be part of families that fall below the poverty line as set forth by the Department of Health, Education, and Welfare. The only other eligibility criteria is that children must be between the ages of three and five years old.

The federal government has mandated that 10% of all Head Start children should come from the handicapped population. The agency's philosophy reflects the spirit of

legislation captioned P.L. 94-142, The Education for all Handicapped Children Act, by providing special services to ensure that children with special needs and handicapping conditions are given every opportunity to reach their full potential. Last year 80 preschool handicapped children were served in this particular practicum setting.

Some handicapped children require special services which are not available through Head Start. In those cases the children spend half a day in a Head Start class and the other half day in a preschool handicapped class operated by their home school district. If the child requires a full time special class placement, then Head Start cannot serve the child adequately and the child must be placed in a special setting appropriate to that child's needs as determined by the Child Study Team of that student's school district.

Although all directives emanate from the federal government, Head Start has a state agency which supervises all of the smaller agencies of each county and within each county central agencies monitor all the Head Start Centers in that specific geographic area.

This particular Head Start agency is dual in nature serving two counties which encompass 930 square miles. The total population for the two counties is 276,385. Four fifths of the population lies within a fifteen mile radius of the major city in the area with the remainder of the population situated inland in very rural areas and along the coastline in numerous seashore communities.

The primary sources of income are related to tourism or farming. According to the 1980 census, 12% of the population is the recipient of welfare, a percentage that has diminished over the past decade.

The racial and ethnic makeup of the area is comprised of about 75% Caucasian, 15% black, 8% Hispanic, and 2% other while the racial distribution of the children in this Head Start setting is 62% black, 18% Hispanic, 20% Caucasian.

There are nineteen Head Start Centers.within the two counties served with approximately 70% situated in rural areas and 30% are in inner city areas. The subject Head Start Program provides services to one in five families in the area.

Each Head Start Center has as many as four classes or as few as one with each class headed by a Preschool Certified teacher who has at least one aide, possibly two, and a Grandmother (an older woman who also helps the teacher). In areas with a high concentration of Spanish speaking children, the second aide is bilingual.

Head Start routinely hires consultants to help serve the special needs of the children and they are hired on an as needed basis or yearly. Some of the consultants who are utilized are in the area of mental health, speech therapy, learning disabilities, and medical specialists of all kinds. Occasionally the consultants are required to deliver direct services to the children, while at other times consultants serve as advisers to Head Start administrators and assist in establishing programs and providing inservice staff

training.

Head Start maintains its own full time staff of nurses and social workers who provide many crucial services through a continuous delivery system. The nurses are capable of handling illnesses of children that occur on site and they also conduct the hearing and vision screenings which are part of Head Start's health component. Further, they assist doctors who provide medical and dental screenings which occur at the Centers.

The social workers make home visits as needed and they also conduct a parent interview with each Head Start parent filling out a social and health history at that time. The teachers are provided with files in their rooms which afford them easy access to this important information about each child.

The education supervisors are responsible for monitoring all Head Start Centers on a continuing basis, checking to see that teachers are satisfactorily performing their jobs and following the Head Start guidelines. Supervisors also act as trouble shooters for any of a variety of problems that can occur at the Centers. Each education superviser is responsible for covering about four or five centers, generally visiting each Center once a week.

Head Start Centers are housed in a variety of different settings including classrooms provided for them within a large elementary school, in churches, community centers, and

city owned buildings not then in use for other purposes. The majority of these settings are old and rundown, with many located in buildings which are reminiscent of the old traditional one room schoolhouses. Classroom space is rented by Head Start and due to limited funds the facilities are often spartan or aged. Identical materials are ordered for all the Centers to assure identical supplies in all Centers. Generally, Head Start Centers in this setting have modest amounts of materials which are in adequate condition and appropriate for preschoolers. Though lacking in some supplies, the Centers are adequately stocked tor carry out their program.

Outdoor equipment is generally poor and in some Centers nonexistent. One Center was limited to use of only portable equipment such as old tires and jumpropes because the area was used for other purposes at other times by other groups. Though a few Centers have access to brand new equipment, few have good outdoor equipment geared to preschoolers.

All classrooms themselves are identically arranged in accord with the Head Start guidelines. The rooms are divided into activity centers by arranging the furniture into designated areas thus enabling each Center to follow the prescribed program and daily schedule outlined in the Head Start operating manual.

The Writer's Role and Responsibilities

For the past five years the writer has been employed as a learning disabilities and speech consultant by Head Start. This is a part time position totaling between two and a half to three days per week depending on the work required to be completed. There are other speech consultants, however, there are no other learning disabilities consultants employed in this setting.

The writer's qualifications for this role are a B.A. in elementary education and an M.A. in learning disabilities. She also holds state certifications as teacher of the handicapped, learning disabilities consultant, speech correctionist, and elementary education teacher.

Prior to employment at Head Start the writer worked as a speech therapist both in schools and clinics and then became the learning disabilities consultant to a school district and chairperson of its child study team. The author also has done private tutoring of both children and adults with learning disabilities.

Presently, in addition to her Head Start position, the writer is employed by the local community college as its learning disabilities consultant, a position which is also part time requiring two days per week.

The writer also serves in a volunteer capacity as a board member of the local community center and the local branch of the Association for Learning Disabled Children and

Adults. In 1986 she received the volunteer service award from the community center while this year she serves as the Youth Committee Chairperson for the Center involving her in overall planning of youth activities and programming for the Center. Both of these activities afford her the opportunity to be involved with children and their parents on different levels and in different settings than those afforded her through her career exposure. Both organizations offer her further opportunities to develop as a person and as a professional while serving her community.

The writer's responsibilities at Head Start include providing inservice training to the staff on special education topics. Workshops are scheduled monthly for the staff and are usually scheduled in the beginning of the term for the whole year. Inservice topics include many other areas in addition to special education so this subject generally receives two workshops at most.

Inservice training also occurs on an individual basis. When a child at any of the centers is referred for either a speech or learning problem, it is the writer's responsibility to evaluate the child. She then assists with the development of the Individualized Educational Plan. The dialogue that occurs between teacher and consultant or between consultant and parent is considered inservice training. Much information on child development, special education techniques and materials, and teaching strategies for preschoolers is imparted during these meetings by the writer.

Providing direct remediation to children with severe speech or learning problems is another aspect of this position. Most learning problems, however, are handled through consultation and followup implemented by the classroom teacher. All children with mild or moderate speech problems are handled in this manner. Only severely impaired children receive speech therapy from a speech therapist.

Another part of the writer's role is to assist with the mainstreaming of the various handicapped children principally through teacher consultation with suggestions for teaching strategies and teaching materials being presented. It is noteworthy that the attitude of the teachers and administrators in this setting is very positive toward mainstreaming.

The writer meets with parents throughout the year since parent involvement is a very important part of the Head Start philosophy. The writer encourages the parents to meet with her to discuss evaluations and therapy and since the parents are often working parents or parents with other very young children, flexibility in arranging meetings assists their occurrence. Meetings may take place casually as the parent appears to pick up the child while others are held as formally planned conferences.

The writer often advises administrators of the concerns over the special education children. These

communications are made through a monthly report which the writer submits to the supervisor of special services and through meetings with administrators. Consultation regarding materials to be ordered for the program, inservice needs, and problems regarding individual children and their special needs are among the topics addressed jin these reports. During meetings with the supervisor of special education services, information is exchanged regarding policy changes both within Head Start and in the state program.

Another aspect of the writer's work is to administer evaluations to detect possible learning disabilities, a format which includes observation of the child in the classroom setting, at least two testing sessions, an interview with the teacher, and a review of the child's records. The process requires two to three weeks to conclude because the subjects are preschoolers which distinguishes them from other age groups by the fact that they tend to have shorter attention spans, tend to be absent more often, and require more extensive observations. The learning evaluation can disclose problems stemming from other handicapping conditions as well.

The writer conducts many of the speech evaluations which include an assessment of language development, voice quality, articulation, and rhythm. Diagnostic tests, informal conversation, oral examination, and a review of the records are the principal methods employed in performing

these evaluations. Another benefit of the procedure is the discovery of problems other than solely speech. The speech evaluation has produced the identification of many hearing handicapped children.

Due to a paucity of office space at the main office much of the writer's work is done at home. Financial considerations limit the time permitted for the duties of the writer since the method of recompense is hourly and the total yearly budgeted amount is specified at the commencement of the year. It is not a large amount and is meant to cover part time services only. It is the responsibility of the administration to assure that the consultants provide appropriate services to children and do not deplete the funds in a nonapproved manner.

Because the only evaluation the writer receives from the administration is a verbal word of praise or an occasional suggestion, the position requires an efficient self motivated educator. The ultimate commendation is being asked to return yearly as no consultant is tenured.

CHAPTER II

STUDY OF THE PROBLEM

Description of the Problem Situation

The problem addressed in this practicum is how to assure that children within Head Start who have special needs are identified and referred in a timely and effective manner. Public Law 94-142, The Education for All Handicapped Children Act, mandates that a free and appropriate education be afforded all handicapped children within specific time lines and to assure compliance it requires programs like Head Start and all agencies receiving federal funding must be consistent with this statute to maintain eligibility for federal assistance. The general philosophy of Head Start is in accord with the act.

Presently, there exists over-referral of some problems and under-referral of others. Referrals for speech problems and behavior problems far outweigh referrals for other handicapping conditions. Many referrals for minor problems which are not due to a handicapping condition according to

the definitions set forth in P.L. 94-142 are initiated in the classroom. Children exhibiting mild speech problems which are developmentally appropriate for their young age are referred mistakenly while children with minor behavior problems are also referred although the problems encountered actually fall within the range of normal behavior for this age group. Ostensibly the teacher is responsible for handling behavior of this kind when it occurs but sporadically.

Conversely, the problem occasioned by under-referral for other handicapping conditions is educationally detrimental. Children with processing problems, hearing problems, motor problems, and behavior problems that manifest themselves through withdrawal rather than acting out, are frequently not referred for special education intervention.

Some of these significant problems continue unreported until the conclusion of the school year. Referring the children at the year's end does not permit special education placement or intervention of any kind in many instances until the succeeding school year. Children who might have benefited from speech therapy, hearing aids, psychological evaluations, behavior modification programs, and various other special services at an earlier time in their lives, thus forfeit that opportunity. Early identification and subsequent intervention has been proven to be of great value to handicapped children.

Under-referral has other ramifications in addition to lack of early intervention for handicapped children. The referral system as it presently exists does not consider or provide help for the child who has a mild problem. Teachers often need assistance with a problem in the classroom involving a child who is not handicapped. When the child does not meet the diagnostic criteria of Head Start for handicapping conditions, there is no eligibility for special services. There is no recourse for the teacher when a child with mild problems in the area of cognitive, motor, social, communication, or emotional skills appears in her classroom manifesting any of these characteristics.

For example, it is possible for a child with a mild speech problem to obtain some special attention directly in the classroom if the teacher or aide is directed in this endeavor by a speech therapist. The child with a mild behavior problem can benefit from some behavior modification if the teacher is cognizant of how to implement this type of program. A teacher can alleviate some of the difficulties evidenced by the child by altering his methods and approaches to teaching these particular children. Parents can become involved and work to change circumstances that are affecting the child's school performance.

In short, there is much that can be done to help children and teachers with the minor problems that occur in their classrooms. With the present emphasis on referral of

handicapped children there is little attention paid to these comparatively minor problems that can often be solved with minor interventions.

Another shortcoming of the referral system as it presently exists is the occassional and unnecessary labeling of children simply for elibility to receive services. This results directly from the problem just discussed. The educators involved know that under the present system a child cannot qualify for special education intervention without initially being classified as Preschool Handicapped and then classified as to the major area of handicap i.e. motor, auditory, visual, cognitive, socio-emotional. For the child with a minor problem, the label is stretched to include him so that a specialist will be involved in the solution of the child's problems. Unnecessary labeling is stigmatizing for the child as well as educationally and intellectually dishonest. The problem a child experiences often does not fit any handicapping condition and to allege that the difficulty encountered qualifies as one is overstating the condition.

Another aspect of the present problem with the referral system is ineffectual use of the consultant's time. Both unnecessary paperwork and testing are concomitant results of the present referral system; resulting from the requirement that comprehensive evaluations be performed on each child referred to special education. The specialist is not at

liberty to work directly on many minor requirements and consequently many children who could be aided so as to function effectively in school, do not receive that assistance.

Under this system a consultant has minimal time for consultation with teachers, parents, or administrators since her time is depleted by scoring tests, writing lengthy reports, and performing lengthy evaluations thus providing inadequate periods for actual consulting.

In an ideal situation when a teacher refers a child for assistance, the teacher and child should get help regardless of whether the child's problem meets the diagnostic criteria for designation of handicapping conditions. Obviously when help is requested a need exists, whether it be that of the child, the teacher, or both.

The preferred procedure would have the teachers refer children within the first six weeks of school. Subsequently, time would not be wasted in needless lengthy evaluations because a prereferral intervention system would be in place to assure that only the child who warrants special education evaluations receives them.

For the past three years workshops have been presented which were designed to help the teachers identify and work with handicapped children in the classes. These

workshops were effective in persuading the teachers to visualize mainstreaming as a workable and preferable philosophy of education of the handicapped, but unfortunately they were not effective in increasing timely and accurate referrals.

Perhaps the reason for this shortcoming was because the workshops did not set forth the time lines as clearly as they are delineated in the law pertaining to referrals and implementation of programs for the handicapped child. Additionally, the information was provided but a single time each year without providing the teachers with a checklist or guide for observing children, requiring them to perform a function (referral) relying solely on memory and intuition. In addition, perhaps the workshops did not sufficiently clarify the importance of early identification with the result that teachers in this work setting became very amenable to having handicapped children in their rooms, yet they failed to become sufficiently efficient at identifying children who might need help. A child whose problem is not readily apparent may actually be the one who needs assistance the most, yet is frequently overlooked when referrals are submitted.

The developmental screening which teachers are required to complete at the commencement of the year and continuously

update throughout the year, is supposed to serve as an alert system for handicapping conditions. The screening employed is a Developmental Inventory, which is a satisfactory general screen for discerning gross developmental lags and assessing developmental progress throughout the year, however it has not been successful in discovering many handicapping conditions. The test is not sufficiently sensitive to detect the various indicators of different handicaps.

Some of the instruments employed are the Head Start Battery and the Bettye Caldwell Pre-School Inventory. The initial screening is often not completed for the entire class until half the year is over and this is the principal detractor in relying on these screenings for identifying handicapped children.

The overall problem is that the existing referral system for children with special needs does not adequately provide for the early identification of these needs or for appropriate intervention to meet these needs.

Evidence of the Problem

Yearly, over the past four years that this writer has been employed in the setting for this practicum, the number of children referred for speech evaluations exceeds the total children referred for all other handicapping

conditions. The large majority of the children referred for speech problems, do not need speech therapy as most are only mildly developmentally delayed and the bulk outgrow their problems by age five.

There exists a significant discrepancy in the number of children referred versus the actual number of classifiable children. The children who are not classified are considered to be mildly or moderately impaired or not impaired at all. In these instances the classroom teacher is expected to work with the children if help is warranted, however in many cases, simply time to mature and exposure to language is necessary. The numbers of truly handicapped children warranting classification remains constant yearly, and is but a small percentage of those children actually referred, proving that many children are needlessly evaluated.

The table on the following page displays what has transpired over the past four years in referrals to the special needs component of this Head Start setting.

The reason for the large increase in number of children referred to the writer in 83-84 was Head Start's inability to locate another therapist to assist that year thereby requiring all children be referred solely to the writer.

TABLE I

NUMBERS OF CHILDREN REFERRED FOR SPECIAL EDUCATION SERVICES

	82-83	83-84	84-85	85-86
Evaluations				
Speech	44	63	40	35
Learning	3	6	4	10
Total	47	69	44	45
Classifiable				
Communication	2	3	6	4
Cognition	1	2	0	1
Socio-emotional	2	0	0	1
Motor	0	0	0	0
Total	5	5	6	6

Yearly, some children with very serious problems are not referred until the middle of the year. For example, last year twenty children with mild to severe hearing problems were not referred until January which is not atypical since the writer has been directed to evaluate children who have serious problems during the latter half of the school year.

During a meeting between the writer and the head of Special Education, the head of Social Work,and all the Education supervisors, it became apparent that all were in accord that a problem existed because referrals are not being made accurately or early enough. They all acknowledged that something had to be done to improve this area of Head Start programming and suggestions were then offered.

During the regular staff orientation in September of this year (1986), the writer presented a workshop/discussion of the proposed prereferral intervention system, which was received enthusiastically by the entire staff. At the conclusion of the workshop the staff was required to fill out workshop evaluation questionnaires; out of 70 teachers, about half added comments that reflected their enthusiastic support of a prereferral intervention system over the existing system. This response indicated that teachers felt the referral system needed improvement.

During the four years this writer has spent in this setting, she has had time to discuss,with the teachers, the

special education services being offered. Many of them confided that they lacked faith that action would result from their referrals, while others have admitted reluctance to chance making a mistake with an inaccurate referral. Still others, during consulting conversations, have revealed their lack of knowledge regarding the various signs of a high risk child are.

Based on the records accumulated by this writer, staff feedback, and strong support at the administrative level for revision of the referral system, this writer concludes evidence of the problem exists.

Further evidence of its existence is in the literature as well as in legislation pertaining to special education. These areas are discussed later in this paper.

Causes of the Problem

One probable cause of the problem is that the teachers lack specific guidelines clearly outlining the specific referral procedure. Referrals for everything from transportation to health care are produced in the same manner employing the same form to cover all potential needs of the child. As a result, referrals often are misrouted to the wrong parties reaching the Special Education coordinator in a very circuitous manner.

The referral form itself is vague perhaps due to its

use in covering so many possibilities the teachers are not clear on how to complete it. In addition, verbal descriptions of the problem and the steps the teacher has taken to solve the problem up to the point of referral, are required. Occassionally teachers do not have the vocabulary or the comprehension of the composition of the problem sufficient to adequately detail it in written form. They comprehend that there is a problem, but they cannot identify it, yet the present referral system obligates the teachers to describe this in detail.

The education supervisors have lacked clarity as to how and when the referrals were to be made and expressed confusion about the use of the same form for all extra services or needs.

They have indicated a lack of awareness of the need for early intervention and, consequently, they have not been sufficiently concerned with referral of children early in the year and have not always been punctual in turning in the referrals they receive.

A major source of the problem is that teachers lack access to something such as a checklist which would guide them in knowing what to look for. They must rely on memory of what they have learned in various workshops, lengthy descriptions in resource manuals and handouts, and results of their developmental screenings. To an extent, these methods do yield referrals of children with special needs,

but they do not do so as effectively and accurately as is possible. The Head Start national headquarters advocates that a checklist be used for identifying handicapped children (HEW, 1978), but does not provide them except within a large manual and there is one manual for each handicapping condition. The teacher who suspects that a child has a particular problem, must research the appropriate manual which is time consuming for a busy preschool teacher.

The teachers lack an easily and quickly usable device to help them in making referrals as methods and devices used presently and listed above are time consuming and lacking in specificity. Teachers of the preschool child are not also required to be certified as teachers of the handicapped. Their certification touches only briefly on the special needs child and thus their lack of knowledge in this area is understandable and the need for a readily available checklist apparent.

Another contributing cause to the problem is the teachers' belief that nothing happens when children are referred that is beneficial to either them or the child in many cases. Many have not been pleased with the type of service they received after making a referral and this complaint has validity. Without prereferral intervention, only the most severely impaired children receive service and the teachers are not assisted with the children who

evidence mild or moderate problems which the teachers feel need attention.

Some of this lack of confidence in the referral system may be premised on inaccurate understanding of the special education consultant's role. Despite the fact that mainstreaming has been in use for many years and the teachers accept its philosophy, they may expect the special education consultant to provide direct intervention with the child in cases where it is not warranted. The system which presently exists fosters that belief by not providing prereferral intervention and by compelling extensive testing and paperwork which consumes much time that could be spent in consultation with teachers.

Another probable cause of the problem is that some teachers are fearful of making a mistake and referring a child who is not really in need of extensive special education interventions. They worry that they will be the cause of labeling a child with some stigmatizing and inaccurate classification which may alter his course in life. This concern results from the requirements that every child who needs special help has to be classified in a category. The teachers in this particular work setting are mostly black and they are very aware of the controversy surrounding the many black children who have been labeled as Mentally Retarded when that was not the problem (Heller, Holtzman, Messick, 1982). As a result, they are very

reluctant to refer children early and prefer to adopt a wait and see attitude.

Review of the Literature

The problem addressed in this practicum is that of how to achieve efficient, accurate, and timely referral of preschool children in need of special services. This is a narrow definition of the problem, however, since a referral system, once in place, has a broad impact on the entire special education system.

As a result of instituting a particular model for a referral system, one is also designating which children shall and shall not receive special education services, which terminology shall be used in referring to the children requiring special education services, how speedily these services will be implemented, how the children will be identified, and the entire set of procedures to be followed by all staff and parents when making a referral. Because of the wide scope of this problem, a literature review must envelop findings and observations on these related and integral areas of the problem.

A review of the literature reveals that the problem of referral, defined broadly, is both a real and present problem. Since the passage of PL 94-142, The Education for

All Handicapped Children Act, in 1975, one referral procedure for special education has been in place in every state in the country and it describes in detail each step that must be taken to refer a child for special education. The states must adopt this law and incorporate it into their existing school administrative code to be eligible for federal funds and revisions must be approved at the federal level. To date, few states have made many revisions as most have accepted the federal version verbatim and required their school systems to adhere to it, but that system has been problematic from the inception.

In a book entirely devoted to developing strategy for equity in special education (Heller, Holtzman, & Messick,1982) the authors state that "the key issue is not disproportionality per se, but rather the validity of referral and assessment procedures" (p.5). The authors cite biases in assessment process as one reason for lack of validity in identification of handicapped children; asserting that characteristics of the students, and the home and family environment lead to erroneous assessments.

Heller et al. (1982) reviewed studies which showed that the Educable Mentally Retarded (EMR) classification was being used to describe black children experiencing learning difficulty in numbers far disproportionate to the population in general. The referral system in place requires that children be "labeled" with some handicapping condition

before they can receive special education. Heller et al. (1982) contend that children who are referred for special education may not be EMR at all, but will yield results in that manner because the measures employed may not yield valid assessments of cognitive skills for particular minority groups.

The root of the problem is twofold:

1) Children needing extra help may not be special education classifiable, but they must be referred to receive any special education. This is the method for funding of extra education services which has been stipulated. allocated.

2) The definition of EMR is misleading when applied to children of different cultural backgrounds because a child may be functioning as retarded in academic areas and actually be of average or above average intellectual ability. His poor performance in school may be due to socio-economic factors, language differences, lack of verbal ability, motivation factors, and other considerations. The I.Q. test reveals only underdevelopment of certain cognitive skills valued by the dominant culture (Heller et al.,1982).

The National Association of Psychologists (1985) warned that it is not a benign action to label as handicapped, children who are low achievers, but this process is followed in order to provide services not otherwise available (National Assoc. of Psychologists, 1985).

There are many educational researchers who believe that it is questionable whether special education can and should serve all students affected with learning and behavior problems under the direct services umbrella (Graden, Casey, & Christenson, 1985; Ysseldyke and Algozzine, 1982). They acknowledge that current referral systems as well as funding patterns have created incentives for doing just that, and they question the necessity of it or the realistic possibility of a funding source large enough to keep pace with the growing special education population (Ysseldyke & Algozzine, 1982).

The reverse of the problem, that of under-referral of certain children who need special education, is addressed by Goodwin & Goodwin (1982) where the authors state there is a need for better training of teachers in early childhood programs with respect to how to identify children with handicapping conditions. Professionals who rely on intuition are denying themselves an important technique of improving their deliberations.

The need for parents, teachers, and all those involved with preschool children to be familiar with the symptoms of various handicapping conditions, and provided with knowledge of simple tests for identifying possible handicapping conditions is stressed by Brewer & Kakalik (1979). They insist that identification without adequate training and preparation will prove inadequate (Brewer & Kakalik, 1979).

Although this would seem self evident, most early childhood programs do not use systematic evaluation strategies (Goodwin & Goodwin, 1982).

The referral decision may be the most important one in a child's life as it sets in motion a process that results in many other decisions (Bryde, 1983). The two main categories that children's referrals generally fall into are academic reasons and/or behavioral reasons (Bryde, 1983). Teachers can dispense with problems in their classrooms by referring them outside when, in many cases, the problems could be solved within the regular education setting (Bryde, 1983).

In an ill fated attempt to stave off the plethora of children into special education, the federal government attempted to return control of the education of handicapped children to the local Boards of Education (The Press, 1984). Had this been implemented, much of P.L.94-142 would have been voided including requirements for obtaining written consent of parents for referrals and program implementations, provision of related services, and 30 day deadlines for evaluations after formal referrals had been made. Then Secretary of Education, Terrel Bell, withdrew his plan yielding to massive public pressure (The Press,1982).

Further evidence of the problem exists in the literature relating to the laws of each state regarding

eligibility and referral.

In New Jersey a study was undertaken to review the entire special education process. Of major concern was the practice of labeling and the large numbers of children being referred and then funneled into special education (N.J. Special Education Study Commission, 1985).

In response to the findings of that study, New Jersey has designed a plan to revise special education in New Jersey which will probably not be implemented until 1987. An important feature of the plan is the insertion of a prereferral intervention step into the existing referral procedure (N.J. State Dept. of Education, 1986). The prereferral intervention guarantees that schools will have an opportunity to try and solve the student's problems in regular education before special education evaluations are administered unless it is blatantly obvious that the student is a candidate for special education due to evidently handicapping conditions.

P.L . 99-457, The Education of the Handicapped Act Ammendments of 1986 allocates funds for implementation of a handicapped infant and toddler program and a preschool grant program. Publication of final regulations for this program may not occur until the Fall of 1987. This statute has far reaching effects on the present preschool programs; among them is the increased eligibility for services based on wider definitions of "handicapped" and non-categorical

reporting of preschool handicapped children. A significant delay (6 mos or 25%) in one or more of the following areas of development: cognitive, speech/language, physical/motor, vision, hearing, psychosocial,or self-help skills constitutes eligibility for early intervention services. Also eligible are children who are medically or biologically at risk because of early health factors which are known to produce developmental delays, including, but not limited to:low birth weight, prematurity, parental substance abuse, maternal age less than 15, and children who are economically disadvantaged and whose primary caregivers have less than a 12th grade education (DEC Position Statements Regarding P.L.99-457, 1987).

The National Joint Committee on Learning Disabilities has added its voice to those concerned about early diagnosis and the premature labeling of preschool children as learning disabled as not being warranted. Only developmental deficits should be noted and education planned accordingly. The committee cites the need for systematic identification programs for all preschool children based on observations, screenings, and high risk factors.

Several different training programs designed to help staff identify problems and refer them as needed, have been developed. One, the Child Development Associate Training Program (Philadelphia Community College, 1976) is divided into training modules. The first module is designed to help

trainees recognize symptoms of preschool children with academic or social problems. It is divided into instructional objectives (for the trainees) and behavioral objectives. In this way, the training can be evaluated by measuring achievement of objectives. Trainees learn the techniques of observation and they are supplied with a behavioral checklist and taught how to use it.

The Portage Project (Wolfe,1982) consists of a training guide funded by Project Head Start and it is divided into various areas of training. The area termed diagnosis deals with identification and referral of handicapped children. Transparencies and handouts accompany workshop lectures. The "Diagnostic Process" is outlined step by step. Each step describes fully what is supposed to occur, who will be involved, and how it will be accomplished. Observation, screening, and parent input are utilized to "diagnose", but no specific screening instrument is mentioned.

Project Head Start gives workshops throughout the year to its staff in order to provide inservice training on special education topics. Official Head Start manuals covering all aspects of special education are available at each Center with a manual available for each type of handicapping condition. Each manual contains a checklist for the teacher to use in detecting these problems in their students with each manual being about 125 pages long.

In addition, Head Start develops a Handicapped Services

Plan for the year. Within that plan the referral procedures are outlined as well as eligibility criteria. The plan calls for each classroom teacher to administer an Individual Developmental Profile to each child in their room. Teachers are advised to use these screenings along with classroom observations and anecdotal records in determining need for referrals (Avery, Atherley, Maloy, & Harris, 1986).

The Northwest Center Child Development Program (Zeitlin & Williamson, 1986) recognizes that diagnosis of children in early childhood reflects an evolving picture that often only becomes clear over time. The program provides full-day childcare for handicapped and non-handicapped children with an IEP developed for each child in the program and services provided as indicated in this document. Children are not "referred" nor are they "classified". Results of evaluation studies of the program show significantly greater developmental gains than normally expected for both the handicapped and nonhandicapped children (Zeitlin & Williamson, 1986).

Project Optimus (Zeitlin & Williamson,1986) is another model which is premised on the theory that a team can best serve children who are referred. The transdisciplinary team jointly designs the program for the handicapped child which is then implemented by the teacher and parent. This plan has been found to reduce overlapping services since all referrals are reviewed by the transdisciplinary team and

only then is a decision made as to which team members need be involved.

The Colorado Study (McNulty, 1984) researched effectiveness of preschool intervention and found that it helped children to enter regular education in elementary school. Aside from obvious benefits to the child, this resulted in a cost saving to the school of millions. This study involving 3000 children, is strong support for the benefits of early intervention and, concomitantly, the need for accurate referrals.

The goals of the prereferral intervention model implemented by Graden & Casey (1985) were: to provide classroom support via consultation, reduce inappropriate referrals for testing, and reduce inappropriate placements in special education. Results revealed overall trends in six schools over two and three year periods. The trends seen were steadily increasing demand for consultation and significant decreases in numbers of students placed in special education.

This writer found no studies designed to determine if checklists, screening, and training programs result in more accurate referrals of special needs children. The assumption behind any of the training programs, or checklists, appears to be that they will enhance the teachers' skill in making referrals just as additional

knowledge and guidelines will enhance one's skill at most tasks. Thus, it seems, a need for evaluation of these programs was not deemed necessary.

Goodwin & Goodwin (1982) are particularly partial to the use of checklists in assisting teachers in their role as referral sources. They maintain that research has demonstrated that checklists are nonobtrusive, can be used to measure any behavior, utilize observational methods, are simple to use and can be completed within a minimum amount of time (excluding the time devoted to observations). They serve as quick information refreshers to those who use them.

In summary, the literature reflects vast concern for the types of referral systems now being employed. There is much evidence that institutions and agencies have been trying to improve the referral system and other aspects of special education in this country. Research, as well as suggested methods and programs for implementing referral systems of various types, are in evidence in the literature. The vast majority of the material is concerned with the need for change. Within the past few years, more information is turning up in research, programming, and in legal ramifications that attempts to address the questions of what changes should be made in the referral system to help alleviate some of the problems presently being encountered in our educational system.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Statement of General Goals

The goals of this practicum experience were to ensure that all children in this particular early childhood program who had special needs received an appropriate educational program, to ensure that children who did not need special educational placement did not receive that placement or identification, and to increase the effectiveness of the referral system presently in place.

Behavioral Expectations

The following objectives were projected for this practicum in order to attain the afore stated goals:

1.To increase the accuracy of the referrals made to the special education division.

2.To increase the efficiency of the referral system presently in place.

3.To decrease the number of chidren classified as handicapped.

4.To increase the number of children referred for learning problems.

5.To decrease the number of children referred for speech problems.

6.To increase the number of children receiving services from the special education division.

7.To increase the teacher satisfaction with the services received from the special education division.

The implementor for all objectives was the writer.

The following is a chart summarizing the objectives of this practicum:

Objective	Measurement	Criteria
1.To increase the accuracy of the referrals	Number of referrals which require intervention	90% of referrals
2.To increase the efficiency of the referral system	Teacher questionnaire	85% of teachers satisfied
3.To decrease the number of children classified as handicapped	Comparison of data for the present year with data from past year	Any decrease
4.To increase the number of children referred for learning problems	Comparison of data for the present year with data from past year	Any decrease
5.To decrease the number of children referred for speech problems	Comparison of data for the present year with data from past year	Any decrease
6.To increase the number of children receiving services from special education	Number of individualized educational plans done for non-classified children	Any increase
7.To increase teacher satisfaction with services from special education	Teacher questionnaire	90% of teachers satisfied

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

In other situations where the same problem has existed, various attempts have been made to solve it. The problem of implementing an efficient referral system which will act as the first step in getting help for handicapped children, is not as simple as it sounds. Whom to refer, how to describe the handicapping conditions, when to refer, and how to assist children not referred, but still in need of services, are all aspects of the problem. The referral decision clearly is the most important one in the special educatio process (Bryde,1983). From it, all other paths lead.

The Portage Project (Wolfe, 1978) and others have developed training programs designed to increase the special education competency of teachers. Checklists are often part of these training programs. There is much support for the use of checklists in early childhood identification programs

(Naron & Perlman, 1981; Colarusso, 1979; Goodwin & Goodwin,1982). The training programs also feature training in observational methods and instruction in the nature of various handicapping conditions.

For this practicum setting, a training program zeroing in on referrals was thought to be a good starting point under the theory that the teachers would make more accurate referrals if they had a checklist to aid them and were better trained in making referrals, specifically. The teachers in this setting have had inservice training in various aspects of special education and the characteristics of the different handicapping conditions. They have not had training on observation techniques and using a checklist until this year. A workshop was given by a psychologist on this topic during the third month of this school year. This training helped prepare the teachers for the implementation of this practicum although that was not the original intent.

The problem has been approached by some model preschool centers. One model center sends all referrals through a child study team evaluation (Zeitlin &Williamson, 1986). This would not be possible in the author's setting for three reasons:

1.There is no standing team.

2.Centers are spread out over a large geographic area making it difficult for all children to be evaluated around the same time by a number of specialists.

3.Due to the part time nature of consultants employed in the author's setting, there is not time for frequent meetings. Phone contacts are used much more often due to budget and time constraints.

A team approach is a good one in determining a handicapped child's status. It is not a necessity when the initial referral is made, though, and may not be needed later either. If a child's problem can be handled in the classroom setting by the classroom teacher, then the appropriate consultant is the only one who needs to be involved in planning for the child with the teacher. A team process for each and every referral is a waste of precious time and money that could be better utilized in helping the child sooner. Only children meeting eligibility for handicapping conditions need be put through this process.

The Northwest Center Child Development Program (Zeitlin & Williamson, 1986) designs an IEP for each child in the program. Services are then provided as needed according to the plan. Special needs are picked up through general screening and formulation of an ongoing developmental profile. This method of handling special needs eliminates much of the seperation between special education and regular education which tends to stigmatize children. It also cancels out the need for referrals unless further testing in areas not covered in the general screening is indicated.

For the most part, Head Start is following this model

since all children receive developmental level testing and also have ongoing developmental profiles formed throughout the year. The child is checked for growth in five general areas four times a year (Avery et al.,1986). This testing is administered by the Head Start teachers. Indicators of special needs are sometimes picked up through this testing, but it is usually too late in the year to be of value. By the time a teacher tests her whole class the first time, three monthes or more have elapsed. The teachers find it hard to complete this testing in addition to their regular teaching duties. All testing is individual and done during the class day. Frequent absences by children at this age contribute to the many weeks it takes a teacher to complete this testing.

An IEP is not done for each child, however. The problem here is mostly lack of time. If assistance were available to teachers in developing these IEP's, it might be feasible. The question is, does every child need an IEP? For the average child who is able to benefit from the standard curriculum with no modifications this does not seem necessary.

The Plan to Revise Special Education in New Jersey operates in much the same way as outlined above. It classifies children only by need for services, stating what service is needed such as Resource Room, speech therapy, full day special education class, and so on (State Dept. of

N.J.,1986). This method of designating services rather than labeling children seems like a very good alternative to the present system. The only criticism the writer has is that labels will occur as a result of placement in special education settings (full day and residential) since classes or schools are designated for specific handicapping conditions. There may not be a solution for this problem, however it may be a moot point, since children with problems severe enough to warrant these kinds of placements are already stigmatized because their handicap is generally evident with or without the label.

The New Jersey plan also incorporates a prereferral intervention step (N.J. State Dept. of Education, 1986). The rationale for this step has been explained fully in other parts of this paper. New Jersey based their decision to implement a prereferral step after much investigation and research as well as public hearings into the matter.

This writer agrees with those who see prereferral intervention as a way to keep more children in regular education who should be there and not diminish services to those who truly need special education.

According to Graden et al. (1985), their study of the development and implementation of a prereferral intervention plan did cut down on referrals to special education significantly. The consultants were utilized much more effectively, and needless paper work and testing were

eliminated. This plan would work equally as well in the writer's setting as long as the demand for consultants does not exceed the supply.

The only problem incurred in the Graden study was that in one school out of six in the study, the teachers refused to use prereferral intervention and insisted on Child Study Team referrals. The researchers relented to heavy pressure and eventually did alter their plan somewhat. In this particular school, children were referred to the Team for any problems, but the Team could then make a determination not to evaluate the child and try prereferral intervention instead.

Government agencies have attempted to solve the problem of over-referral by putting caps on the numbers of children who can be referred for each handicapping condition (Brewer & Kakalik,1979). This results in short changing some children. As long as special education is the only alternative for children experiencing problems in school, there will be a steady flood of children into special education.

Description of Selected Solutions

The solution strategy chosen was the implementation of a prereferral intervention program. The problem of assuring

that children who have handicaps are referred quickly and accurately for assistance is one which calls for an efficient referral system. Prereferral intervention vastly improves the usually cumbersome and time consuming referral process to special education by eliminating some of the steps in that process as well as much of the paperwork.

The solution selected also has the potential of providing more services to more children with problems without resorting to formal classifications of handicapping conditions. Under the prereferral intervention system, children may receive assistance from special education consultants without receiving a label first.

Prereferral intervention encourages early identification of learning problems of all kinds. Early identification has been widely accepted within the field of education as an important goal to be pursued. Research has supported the efficacy of early identification as a preventive measure capable of preventing eventual placement in special education and, as a method of giving children with special needs a plan of remediation to help them catch up to their peers.

Additionally, prereferral intervention may be the most viable and fair solution to the problem of over-referral to special education. It encourages teachers to take another, less drastic approach to the problems they face in their classrooms. This is especially important at the preschool

level where diagnosis of handicapping conditions is more difficult to do with certainty. A child who initially appears to be handicapped may not exhibit the delays or deviant behavior after a few months of exposure to preschool.

The writer chose this particular solution partially because it was feasible in this setting. The setting for this practicum has limitations due to financial considerations, expanse of geographic area encompassed, and limited personnel. Institution of a prereferral intervention plan required no outlay of funds, no additional personnel, and was possible to implement in a setting which is actually a series of different settings spread out over a wide geographic area.

Another important consideration in choosing this particular solution was that it is part of the overall solution that the state of New Jersey has selected to address the problems of its special education system. It was encouraging to know that, after extensive research, New Jersey's department of special education included prereferral intervention as part of their proposed solution to the problems which have arisen in the provision of special education.

Results of the study conducted by Graden and Casey (1985) substantiated the benefits of prereferral intervention as significant decreases in placements in

special education and increased requests for consultation services occurred in that research. These positive results further encouraged the writer to institute a prereferral intervention plan.

The first step in the implementation of this solution was the development of a set of checklists for the teachers to use in identifying children with special needs. The checklists were distributed to every Center along with revised referral forms designed specifically for referrals to special education.

The second step was to begin responding to requests made for prereferral intervention throughout the three month implementation period. Teachers had the option of requesting either a prereferral consultation or a formal referral for a complete special education evaluation. If the teacher requested a prereferral consultation, the writer went to the site and provided teacher consultation, screenings, child observations, a review of the child's records, and, in some cases, parent conferences. Consultations could result in an immediate referral for complete evaluations and probable classification as preschool handicapped, a prereferral intervention plan, a referral to a different type of consultant such as audiologist or psychologist, or no action needed other than teacher consultation.

When a decision was made to provide prereferral

intervention for a child, the writer devised an individualized educational plan which consisted of a record of findings of the initial consultation, goals and objectives, materials, and teaching strategies. A written copy of the plan was provided for the teacher and was reviewed with her.

The next step of the practicum consisted of a monitoring phase. The teachers were contacted on a biweekly basis either by phone or in person to discuss the progress of the children on prereferral intervention plans. If the teacher and the writer determined the need for alterations in the plans, they could be made at this point. All children on prereferral intervention plans were seen by this consultant at least once in person during the monitoring phase.

Midway into the implementation period, a meeting was held with the education supervisors to discuss how the prereferral intervention plan was working. Problems that had surfaced were discussed. The concept of prereferral intervention was reviewed by this consultant as were the steps in referrals to special education. A gathering of all the teachers would have been more desirable, but this was not feasible due to scheduling of large workshops a year in advance. The education supervisors are in contact with all the teachers in this practicum setting on a weekly basis so it was assumed that they would carry back information gained and clarifications received.

During the practicum implementation, records were kept of numbers of referrals, numbers of children who received prereferral intervention plans, numbers of children who were referred and needed no intervention, numbers of children who required immediate special education referrals, numbers referred for speech problems, and numbers referred for learning problems.

During the last month of the practicum, interviews were held with each teacher using the questionnaire constructed by the writer as a guide. This was found to be more satisfactory than merely handing the teacher a questionnaire and asking her to complete it. The personal contact opened up the way for more dialogue and thus more insight into the reactions of the various teachers to the practicum project. The questionnaire obtained qualitative and quantitative information regarding the prereferral intervention implementation.

At the end of the three month implementation period, a conference was held with each teacher and a determination was made as to whether the child needed further evaluations, how much progress had been made, and what effect the intervention had had. A decision was made as to what course of action would be taken with the child from that point on; extension, modification, or termination of the prereferral intervention plan.

CHAPTER V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

An analysis of the results of the implementation of a prereferral intervention plan is presented in Table II on the following page. A comparison of the data generated this year is compared with that of the previous year.

The total number of referrals made this year, 44, remained about the same as in previous years. Of the 44 referrals, 41 received consultations. The 3 which did not, were due to excessive absences on the part of these children combined with unanticipated Center closings for various reasons.

The number of children who needed intervention of some kind was 29. This included those with mild, moderate, and severe problems. This number represents about 75% of the total seen for consultation. Thirteen of these children were placed on prereferral intervention plans implemented by the classroom teacher, 8 were placed on prereferral intervention plans implemented by the teacher and the writer, and 8 were referred to other specialists or received only teacher consultation. This entire group represents about 75% of the total number referred.

TABLE II

A COMPARISON OF PREVIOUS AND PRESENT YEAR REFERRAL DATA

Evaluations	85-86	86-87
Speech	35	24
Learning	10	20
Total	45	44
Classifiable		
Communication	4	3
Cognition	1	7
Socio-Emotional	1	0
Motor	0	0
Total	6	10

Only 12 children were referred who did not warrant any intervention. These children had mild behavior problems or deviated minimally from developmental norms in either speech or other developmental areas and all of these children would be considered within the normal range of development and behavior. Interestingly, approximately 3/4 of these children were referred by the same two teachers.

Ten children received prereferral intervention and still required subsequent evaluations for possible classification as handicapped. The major areas of developmental delay seen in these children were in the areas of communication and cognition or a combination of the two. The children who exhibited speech and language delays in this group were unintelligible even after three months of speech therapy received weekly with followup lessons taught in the classroom by the regular teacher. The group whose deficits manifested themselves in the areas of cognition exhibited continued delays in the mastery of preacademic skills and fine motor skills. This latter group would be considered high risk for learning disabilities in future school years.

The first objective was not achieved since, from the total number of children referred, there were twelve who required no intervention. It can be inferred that these referrals were invalid and thus, approximately 75% of the total referrals submitted were accurate. The criteria for

achievement of the objective was set at 90% accuracy for referrals received as measured by the number found to be in need of some kind of intervention. However, a rate of 75% accuracy is an improvement over the rate of accuracy in past years.

The second objective was not achieved according to the results of the teacher questionnaire. About 50% of the teachers interviewed were dissatisfied with the speed and efficiency of the referral system. The criteria for achievement of this objective was that 85% of the teachers would feel satisfied with the efficiency of the referral system. About 50% of the teachers complained that response to their referrals was still taking too long for their satisfaction since more than a month elapsed in some cases before a consultant responded to the referral.

There was a decrease in the number of children classified as handicapped this year since none of the 44 referrals submitted received that classification during the implementation period. Thus, the third objective, to show any decrease in the number of children classified, was achieved, however ten children were identified who may require classification in the future in order to receive services, especially in the area of speech and language. This is an increase of 50% over the number detected last year as being classifiable. This was an unexpected outcome and may be due to the improved early identification

procedures implemented in this practicum, or the chance presence of a larger number of children with severe problems appearing in the population this year.

The fourth and fifth objectives were achieved as there was an increase in the number of children referred for learning problems and a decrease in the number referred for speech problems. This reflects greater accuracy in making valid referrals since, in past years, there has been over-referral of speech problems of a minor nature and under-referral of learning problems of all kinds.

The number of children receiving special education services increased greatly with 41 children receiving at least consultations and 29 of those children receiving services beyond evaluations. Twenty-one children received educational plans, a number which remained at or around five children in past years as only those classified received such detailed plans. Thus, the sixth objective, that of increasing the scope of special education services offered to children, was achieved.

The seventh and final objective was achieved with over 90% of the teachers indicating satisfaction with the overall special education services provided. The only evidence of dissatisfaction was in the area of length of time involved in receiving a response to a referral and that was the case in only 50% of the teachers interviewed. The majority were pleased with prereferral intervention program and especially with the checklists provided for early identification.

During the implementation period, all the teachers referred at least one child for special education consultation and the average teacher referred between one and three children. The teachers expressed satisfaction with the prereferral intervention plans and said they had time during the class day to implement these plans. None felt a lack of training or ability needed to accomplish this and none felt a consultant was needed to implement the plans except in the case of children with severe problems.

The majority of the teachers agreed that the prereferral intervention system has the potential to bring aid to the children faster and to reach more children than previously serviced by special education. They valued the time that prereferral intervention afforded them to work with the children and observe them more extensively before requesting special education evaluations and risking hasty classifications and placements in special education. They concurred unanimously that prereferral intervention prevents unnecessary and/or premature labeling of children.

Conclusions

The first two general goals of the practicum; to ensure that all handicapped children received an appropriate educational program and to ensure that children who did not

need special educational classification were not labeled unnecessarily, were achieved. The third overall goal, that of increasing the effectiveness of the referral system was partially achieved.

The entire issue of classification as a prerequisite for special services and the resultant problems of premature labeling, stigmatization, and denial of services to children who do not fit the diagnostic criteria for classification, was eliminated. This year, children with mild and moderate speech and/or learning received increased assistance from the special education division. Their progress and development over time, possibly as a result of the interventions employed, resulted in a number of children who would have been classified in previous years in order to obtain services, completely avoiding that dilemma.

Referral accuracy increased greatly as evidenced by the larger numbers of children with learning problems who were referred and the decreased number of children referred for speech problems. The problems of under-referral and over-referral for those particular handicapping conditions were probably impacted upon most by the provision of the behavioral checklists. Another possible reason for the change in referral trends may have been due to the fact that the teachers knew they would receive assistance in dealing with learning problems of varying degrees, not just those of a severe nature.

The teachers in this setting were very cooperative and became involved easily with the mission of this practicum and the administrators needed little persuasion to agree to the practicum proposal. In essence, fertile soil for implementing a new idea was found. Two recent large scale studies conducted by Albrecht (1984) and Knoff(1984), found the same willingness to implement mainstreaming and the same pro-normalization sentiments among educators that this writer encountered. Although conflicting research exists which contends that teachers are opposed to mainstreaming, the reason for the pro-mainstreaming/anti-classification philosophy prevelant in this setting may be the high number of black and Hispanic personnel employed. They are very aware of the issue of overclassification of minority children as mentally handicapped.

Results of this practicum indicate that a prereferral intervention program can be beneficial to teachers by providing them with consultation and planning for all the children they view as needing adjustments to the regular curriculum. It gives them the confidence and the tools to handle children they may have perceived as too difficult to teach. Because teachers are integrally involved throughout the prereferral intervention plan, they do not feel condescended to by outside specialists. The message given to them is: You can do it, if you know how. From the teachers' perspective, prereferral intervention offers the

help they have been requesting in a nonthreatening, accommodating manner.

Many children showed growth in academic and social areas of development while on prereferral intervention plans including some of the children who could be considered severely impaired. This growth was achieved in a mainstreamed setting which the bulk of the research in special education strongly supports. The implications are that mainstreaming is possible and can be successful for many preschoolers with handicaps of varying degrees.

Implications for teacher inservice training became clear during the implementation period. The areas in which they were weak came to light while their strengths became evident at the same time. Particular teachers who needed more inservice than others were identified by over-referral of children and by their stated misconceptions about some early childhood education principles.

In summary,although there are children who require such specialized education that it can not be offered in a regular classroom, there are many children who can receive specialized education within a mainstreamed setting.

The movement for rights without labels is gaining momentum across the country. Three groups recently published a position paper on the topic as well as

guidelines for providing rights without labels. They are: The National Association of School Psychologists, the The National Association of Social Workers, Inc., and the National Coalition of Advocates for Students. Their position is that children who would be classified in a categorical system, need not be in many cases excepting the most severe, and can receive special services in regular settings with the best success for all concerned. A primary recommendation they make is that prereferral screening/intervention methods be conducted by regular school personnel with the support of special education resources,i.e. speech therapists, psychologists, social workers, special educators, etc. (Education Week,1987).

The results of this practicum support the research which concludes that the prereferral intervention model demonstrates initial promise for delivery of services which will help teachers to teach better and help students to learn better.

Recommendations

1.Determine whether or not the setting has the resources needed to implement the system, i.e. aides, materials, space for providing individualized assistance in the classroom, time for providing that assistance, and access to consultants as needed.

2.Provide inservice training on all aspects of the prereferral intervention system prior to implementation.
3.Route referrals to the appropriate consultant in as direct a manner as possible. If others need to see the referrals as well, provide copies.

Plans for Dissemination

Dissemination of the results of this practicum will begin with a presentation to the staff of this practicum setting at the orientation meeting prior to the commencement of school. The teachers should be encouraged to hear of the largely positive effects of the new referral system. At this time, proposed changes and improvements in the system for the coming year will be discussed. Continuation of the prereferral intervention program for this Head Start setting on a year long basis is planned.

Results of this practicum may also be disseminated at certain Head Start meetings in the state. The writer will attempt to get on the agenda to present the results of the this practicum to other Head Start projects in her state.

The writer will also make an effort to speak to area preschools about this new and innovative way to approach the child with special needs. Many area preschools have inservice training for their staff as well as parent discussion groups and programs. Any of these would be good

forums for the writer to present some of the information associated with this practicum.

Since the state of N. J. is presently preparing to implement a completely new special education program which features prereferral intervention, the writer will contact the state office of special services to let them know of her project. They may be interested in having her present her practicum to other early childhood educators.

The author also plans to contact the National Association for the Education of Young Children about the possibility of presenting the results of this practicum to their members at one of their conferences. The Council for Exceptional Children will also be approached about presentation at one of their conferences.

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APPENDIX A

OBSERVATIONAL CHECKLIST FOR HEARING IMPAIRMENT

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OBSERVATIONAL CHECKLIST FOR HEARING IMPAIRMENT

	Yes	No
Does child fail to respond to loud, unusual, or unexpected sounds?		
Does the child fail to respond to communication that excites other children?		
Does the child fail to understand or respond to instructions or greetings when he does not see the speaker?		
Does the child frequently say "huh" or "what" or show other signs of not understanding what has been said?		
Does the child use very little speech?		
Does the child's voice seem too high pitched, too low pitched, or too nasal?		
Does the child have poor articulation?		
Is the child's speech full of words and sentences that cannot be recognized?		
<u>Other Behavior</u>		
Does the child have a short attention span?		
Does the child breathe with his mouth open?		
Does the child tend to play alone?		
Is the child easily frustrated or distracted in a group?		
Does the child always seem to be watching your mouth when you speak?		
Does the child communicate frequently through gestures, grabbing, or pulling?		
<u>Medical History</u>		
Is there a history of earaches or ear infections?		
Does the child complain of earaches, ringing or buzzing in the ears?		
Does the child have allergies or chronic colds?		
Has the child had a disease accompanied by high fever?		
Do parents say that they have wondered if the child has a hearing loss?		

APPENDIX B

OBSERVATIONAL CHECKLIST FOR SPEECH AND LANGUAGE IMPAIRMENTS

APPENDIX B

OBSERVATIONAL CHECKLIST FOR SPEECH AND LANGUAGE IMPAIRMENTS

	Always	Often	Rarely	Never
Reception				
Child can not point to common objects named				
Child can not understand simple one step directions				
Child seems confused when asked a question such as "What do you do if you are thirsty?"				
Expression				
Child has not started talking yet				
Grammar and sentence structure seem faulty				
Uses unusual word substitutions frequently				
Child leaves out many words in a sentence				
Articulation				
Child uses mostly vowel sounds				
Child leaves out the first sound in many words.				
Most of what he says can not be understood				
Child mispronounces many (at least 4) speech sounds				
Voice				
The child's voice is so soft, he can barely be heard				
Child's voice continually sounds hoarse				
Child's speech is hypernasal (seems to be comming through his nose)				
Rhythm				
The child has noticeable difficulty and seems to struggle trying to say words or sounds				
The child is aware of this difficulty				
There is an abnormal amount of hesitation, repetition of sounds or words and/or prolongation of sounds or words				

APPENDIX C

OBSERVATIONAL CHECKLIST FOR LEARNING DISABILITIES

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OBSERVATIONAL CHECKLIST FOR LEARNING DISABILITIES

Motor Skills	Yes	No	Sometimes
Does the child stumble often, or appear awkward?	[]	[]	[]
Does the child seem afraid of or unable to use stairs,climbing equipment, or tricycles?	[]	[]	[]
Can the child hop on one foot?	[]	[]	[]
Is the child capable of dressing himself except for tying shoes?	[]	[]	][
Does the child hold a pencil or crayon appropriately between thumb, index finger, and middle finger?	[]	[]	[]
Does the child switch hands while coloring or eating?	[]	[]	[]
Can the child cut with scissors?	[]	[]	[]
Can the child copy a cross?	[]	[]	[]
Can the child color inside a circle with any accuracy?	[]	[]	[]
Does the child appear awkward in eye hand coordination tasks such as pegs, puzzles, coloring, beads and leggos?	[]	[]	[]
Cognitive Skills			
Can the child answer simple questions about a story?	[]	[]	[]
Does the child give resonable answers to questions?	[]	[]	[]
Does the child demonstrate simple problem solving such as completing puzzles, following patterns for bead stringing?	[]	[]	[]
Does the child seem to have trouble learning the preacademic skills such as letter naming, counting, picture identification?	[]	[]	[]

	Yes	No	Sometimes
Can the child repeat a sequence of three numbers or things (objects) in order which are spoken to him?	[ ]	[ ]	[ ]
Does the child have trouble remembering things?	[ ]	[ ]	[ ]

Social Skills

Does the child engage in at least two disruptive behaviors (tantrums, fighting, screaming) a day?	[ ]	[ ]	[ ]
Does the child seem to be in constant motion?	[ ]	[ ]	[ ]
Does his attention span seem shorter than the other children's?	[ ]	[ ]	[ ]
Does the child appear withdrawn?	[ ]	[ ]	[ ]
Does the child play alone and seldom talk to other children?	[ ]	[ ]	[ ]

*If your answers fall in the grey boxes on a number of skills, a learning problem may be indicated.

APPENDIX D

TEACHER QUESTIONNAIRE

APPENDIX D

TEACHER QUESTIONNAIRE

1.Did you refer any children to special education services this year? How many? For what reason (speech, behavior, learning, hearing?)

2.If you referred no children this year, is there a reason other than the fact that no child required this assistance?

3.Did you receive consultation from a consultant on all children referred? How many did not receive consultations?

4.Did you use the observation checklists to help you determine whom to refer? Did you find them helpful? How could they be improved?

5.Did any of the children you referred receive prereferral intervention plans? How many?

6.Were these prereferral intervention plans helpful to you? If not, how would you improve them?

7.Do you think that the prereferral intervention system gets help to the children faster than the old referral system?

8.Do you think that the prereferral intervention system prevents children from being labeled as handicapped unnecessarily?

9.How many children who received prereferral intervention still required special education evaluation afterwards?

10.How would you improve the special education service delivery system so it benefits children and teachers?